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BEFORE THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA

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In The Matter of Charges and Complaint Against STEPHEN SELDON, M.D., Respondent.	NO. Case No. 08-10701-1 FILED November 7, 2008 CLERK OF THE BOARD

COMPLAINT

The Investigative Committee of the Board of Medical Examiners of the state of Nevada, composed of Charles N. Held, M.D., Chairman, and Jean Stoess, M.A., Member, by and through Lyn E. Beggs, General Counsel for the Nevada State Board of Medical Examiners, having a reasonable basis to believe that Stephen Seldon, M.D., hereinafter referred to as Dr. Seldon, has violated the provisions of NRS Chapter 630, hereby issues its formal Complaint, stating the Investigative Committee's charges and allegations, as follows:

1. Dr. Seldon is currently licensed in active status, and was so licensed by the Nevada State Board of Medical Examiners, hereinafter referred to as "the Board," pursuant to the provisions of Chapter 630 of the Nevada Revised Statutes, at the time of the incidents in question.

2. Patient A is the patient at issue and was a forty-eight year old female at the time of the matter in question.

3. Patient A began to see Dr. Seldon in 2003 when she saw him for a cosmetic injection of Restylane. Patient A continued to see Dr. Seldon over the course of the next four years for a variety of cosmetic procedures including cosmetic injections, a combination face lift, a thread lift and a lower blepheroplasty.

4. Medical records for these procedures are virtually non-existent and do not accurately and completely document the treatment of Patient A.

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5. In October 2007, Patient A opted to undergo a tumescent liposuction treatment on a variety of areas, the majority of the liposuction to be performed in her abdominal area. On October 9, 2007 she signed a variety of waivers and a consent form regarding liposuction.

6. On October 11, 2007, Patient A presented to Dr. Seldon's office for the liposuction procedure which was begun without the use of general anesthetic or deep sedation as is standard in tumescent liposuction procedures.

7. The procedure was not completed as Patient A was apparently experiencing too much pain to continue without anesthesia and accordingly the procedure was not completed.

8. Patient A also wrote a check to Dr. Seldon for $750 with the memo indicating it was for "Dr. Singel, Anesthesiologist." Dr. Singel is a podiatrist, not a medical doctor; however, there is no indication that Patient A was ever made aware of this fact or that she gave an informed consent to have him provide anesthesia during the procedure.

9. Patient A returned the following day, October 12, 2007 for performance of the tumescent liposuction procedure and according to the minimal medical record, "twilight" anesthesia was utilized.

10. The medical records for the procedure are minimal and are not accurate and complete.

11. Patient A was released from Dr. Seldon's office and was provided a prescription for Percocet. She was to return the following morning for a post-operative visit.

12. Patient A experienced pain and jitteriness during the night and early morning hours after the procedure and she took some of the prescribed Percocet to relieve her pain. The morning of October 13, 2007, Patient A's son phoned Dr. Seldon's office indicating that he would not be bringing in his mother as she was finally resting after a difficult night.

13. Later on October 13, 2007, Patient A's son went to Dr. Seldon's office to obtain a different pain medication for her as it was felt that the Percocet may have caused some of her jitteriness.

14. Patient A's son contact Dr. Seldon's office twice more on October 13, 2007, the last time reporting that she was bleeding, including a large amount of blood being found in the toilet

15. At no time on October 13, 2007 did Dr. Seldon personally speak with Patient A's son.

16. Patient A's son and another family member eventually contacted emergency medical services and she was transported via ambulance to St. Rose Dominican Hospital where she was seen in the emergency room at approximately 7:00 p.m.

17. Patient A was admitted to the ICU where her condition worsened. She coded and although resuscitation efforts were made, she eventually died in the early morning hours of October 14, 2007.

18. An autopsy report was completed which noted the cause of death as multi-organ failure due to acute microangiopathic hemolytic anemia due to tumescent liposuction procedure. The autopsy report also noted at least thirty-five irregular and curvilinear puncture wounds on the skin on the abdomen, upper legs and buttocks. The underlying soft tissue demonstrated broad areas of hemorrhage and necrosis.

Count I

19. NRS 630.040 defines malpractice as the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

20. NRS 630.301(4) provides that malpractice is grounds for initiating disciplinary action against a licensee.

21. Dr. Seldon failed to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances when he performed liposuction on Patient A utilizing a high number of incisions which is below the standard of care, and accordingly Dr. Seldon has violated NRS 630.301(4) and thus is subject to discipline.

Count II

22. Dr. Seldon failed to use the reasonable, care, skill, or knowledge ordinarily used under similar circumstances when he allowed a podiatrist to act as anesthesiologist during the procedure and did not inform Patient A of the fact that the individual was a podiatrist nor gain her informed consent for him to provide the anesthesia; accordingly, Dr. Seldon has violated NRS 630.301(4) and thus he is subject to discipline.

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Count III

23. NRS 630.3062(1) provides that failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient is grounds for initiating disciplinary action against a licensee.

24. Dr. Seldon's medical records regarding the diagnosis, treatment and care of Patient A are not complete and accurate records and include little to no information.

25. Dr. Seldon's failure to maintain timely, legible, accurate and complete medical records related to Patient A's care and treatment violates NRS 630.3062(1) and thus he is subject to discipline.

WHEREFORE, the Investigative Committee prays:

1. That the Nevada State Board of Medical Examiners fix a time and place for a formal hearing;

2. That the Nevada State Board of Medical Examiners give Dr. Seldon notice of the charges herein against him, the time and place set for the hearing, and the possible sanctions against him;

3. That the Nevada State Board of Medical Examiners determine what sanctions it will impose for the violation or violations committed by Dr. Seldon;

4. That the Nevada State Board of Medical Examiners make, issue and serve on Dr. Seldon its findings of facts, conclusions of law and order, in writing, that includes the sanctions imposed; and

5. That the Nevada State Board of Medical Examiners take such other and further action as may be just and proper in these premises.

DATED this 7th day of November, 2008.

INVESTIGATIVE COMMITTEE OF
THE NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: _____
Lyn E. Beggs
General Counsel and Attorney for the Investigative Committee

VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF DOUGLAS)

CHARLES N. HELD, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against the Respondent, he believes that the allegations and charges in the foregoing Complaint against the Respondent are true, accurate, and correct.

DATED this 7th day of November, 2008.

CHARLES N. HELD, M.D.

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CERTIFICATE OF MAILING

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on the 7th day of November 2008, I served a file copy of the COMPLAINT, NOTICE OF PREHEARING & HEARING, PATIENT DESIGNATION, by mailing via USPS certified return receipt to the following:

Stephen Seldon, M.D.
1701 N. Green Valley Pkwy Bldg. 5 Ste. A
Henderson, NV 89074

Dated this 7th day of November 2008.

Angelia Donohoe
Legal Assistant

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